Contemporary Challenges to Oral and Maxillofacial Surgeons' Ethics and Professionalism in Colombia: A Principle-Based Perspective *

Desafíos contemporáneos a la ética y profesionalismo de los cirujanos orales y maxilofaciales en Colombia: una perspectiva desde los principios

Desafios contemporâneos à ética e ao profissionalismo dos cirurgiões maxilofaciais na Colômbia: uma perspectiva baseada em princípios

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ABSTRACT

Background: continuous changes in our economic conditions and social environment over the past few decades have contributed to the emergence of ethics and professionalism challenges in the practice of oral and maxillofacial surgery. **Purpose:** to encourage reflection and to regain conscientiousness about the ethical and professional standards to be pursued in clinical practice. **Methods:** By using the four moral principles of biomedical ethics as a theoretical and systematic framework some potential ethical dilemmas faced by oral and maxillofacial surgeons daily and their impact are described and analyzed. **Findings:** Ethical issues including endangerment of informed consent, potential harms to patients and unfair treatment to persons were illustrated. **Conclusions:** As the landscape of oral and maxillofacial surgery changes, new conditions can erode the ethics principles embedded in our code of ethics.
Keywords: bioethics; dentistry; ethics; informed consent; maxillofacial surgery; personal autonomy; principle-based ethics; professionalism; standard of care

RESUMEN

Antecedentes*:* cambios continuos en nuestras condiciones económicas y en el entorno social durante las últimas décadas han contribuido a la aparición de comportamientos que impactan negativamente la práctica profesional y presupone desafíos éticos en cirugía oral y maxilofacial. **Objetivo:** fomentar la reflexión y recuperar la conciencia sobre los estándares éticos que se deben procurar y mantener en la práctica clínica. **Métodos:** se utilizaron los cuatro principios bioéticos como marco teórico y sistemático para describir dilemas éticos comunes que potencialmente pueden enfrentar los cirujanos orales y maxilofaciales. **Resultados:** dilemas éticos que incluyen el comprometimiento del consentimiento informado, daños potenciales a los pacientes y el trato injusto a las personas han sido descritos. **Conclusiones:** A medida que el panorama de práctica de la cirugía oral y maxilofacial cambia, nuevas circunstancias pueden erosionar los principios éticos incorporados en nuestro código de ética.
Palabras clave: autonomía personal; bioética; cirugía maxilofacial; consentimiento informado; estándares del cuidado; ética; ética basada en principios; odontología; profesionalismo

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RESUMO

Antecedentes: mudanças contínuas em nossas condições econômicas e ambiente social nas últimas décadas destacaram os desafios éticos e profissionais na prática da cirurgia oral e maxilofacial. **Objetivo:** estimular a reflexão e resgatar a consciência sobre os padrões éticos a serem perseguidos na prática clínica. **Métodos:** utilizando os quatro princípios morais da ética biomédica como referencial teórico e sistemático, descrevem-se e analisam-se alguns dilemas éticos enfrentados diariamente pelos cirurgiões maxilofaciais e seu potencial impacto. **Resultados:** questões éticas, incluindo a ameaça ao consentimento informado, possíveis danos aos pacientes e tratamento injusto às pessoas, foram ilustradas. **Conclusões:** à medida que o cenário da cirurgia maxilofacial muda, novas condições podem corroer os princípios éticos incorporados em nosso código de ética.
Palavras-chave: autonomia pessoal; bioética; cirurgia maxilofacial; consentimento livre e esclarecido; ética; ética baseada em princípios; odontologia; padrões de cuidado; profissionalismo

INTRODUCTION

Since its inception as a dental specialty in 1958 (1,2), the practice of oral and maxillofacial surgery in our milieu has changed over the years. Changes in the economic, social environment and in the nature of the health care system have contributed to the emergence of de-professionalizing forces that currently challenges ethics and professionalism in clinical practice (3). Oral and maxillofacial surgeons are obliged to know and to do what ought to be done, that is, to honour the core values and principles embedded in our professional code of ethics (4). However, training flaws, conflicts of interest, weak regulatory bodies, limited practice opportunities and a commercialized health care market can elicit potential challenges that erode professional behaviour, and thus compromise the reputation and integrity of the specialty (3,5,6). In these circumstances, with a complex present and a murky future, becoming aware of and reaffirming our ethical and professional responsibilities with trainees, patients, colleagues, and society is of paramount importance. This paper is designed to provide oral and maxillofacial surgeons with a broad outline of the common ethical problems that they are likely to encounter in their daily practice.

During our career, professionalism and ethics are inextricable intertwined. Both form part of the essence and daily practice of oral and maxillofacial surgery. As specialists we are distinguished by our specialized training, body of knowledge and technical skills as well as our commitment to provide special service to others. Likewise, as members of a regulated learned profession we are committed and obliged by law to specific standards that must be acknowledged and demonstrated in our behaviour and performance. These specific obligations comprise our deontological framework and moral responsibilities, namely the ¨ethos¨ of our profession. Therefore, ethics is the conscious and unconscious application of the standards that should guide our professional decisions about the right thing to do in a specific situation (4-8).

The analysis of some contemporary ethical and professional challenges faced by oral and maxillofacial surgeons in clinical practice, and that are worthy of their review can be addressed based on Beauchamp and Childress' four *prima facie* moral principles of biomedical ethics –autonomy, beneficence, nonmaleficence and justice. These principles are embedded in our code of conduct and as comprehensive norms of obligation lead to the formulation of substantives rules, which are more specific and guide our judgment and actions (4,9,10).

Certainly, a principled-driven practice is one part of ethics. The other part is the character-driven aspect, the practice of virtues, namely, to act in accordance with moral principles with a proper characteristic motive (11). Our code notes the need for acting with responsibility, honesty, and prudence. Similarly, it exhorts us to be considerate, caring, and loyal (4). These are examples of virtues that allow us to use the aforementioned principles wisely and to take excellent choices and proper decisions.

Principles and virtues are integrally related. Any act that breaks the connection between our moral emotions, convictions, and actions and that generates a negative reactive attitude expresses a vice (12,13). Vices such as dishonesty, arrogance, envy, and greed lead to actions (e.g., failure to fulfill responsibilities, breach confidentiality; mistreat, interact abrasively with, or exploit trainees, patients, and colleagues) that undermine and hinder principles and virtues' moral labor and complicate the entire corpus of current ethical and professionalism concerns.

On respect for autonomy

The principle of autonomy embraces respect for persons, it means self-rule or self-directing and refers to the individuals' capacity to make choices relevant to their needs and in their best interests, free from the will of others. The right to decide based on their own beliefs and values (10). Respect for patient's autonomy encloses the virtue of honesty, which implies the provision of adequate and truthful information to enable patients to make the best informed and conscious decision. In this regard, respect for patient's autonomy is the philosophical and ethical –*as well as legal*– basis of the standard of informed consent (14-16).

Informed consent is the core aspect of the clinician-patient relationship. It is a continuous process, –not a signature on a form–; a conversation, which can involve multiple visits between the clinician and a reasonable patient –*or proxy*– about the nature and purpose of the treatment or surgical procedure. It includes a discussion on the material risks, likely complications, benefits, and consequences of no treatment. Alternative treatments that may be available also should be considered. It also includes the right to refuse care. There should be the opportunity to ask questions, to discuss the treatment choice and to reflect on the decision. Finally, to clear indicate the ultimate decision free from manipulation or any other form of influence (14-17). Then, it is nowadays expected that oral and maxillofacial surgeons always take the time to provide patients with adequate clinical information, ensure they understand what is being informed and voluntarily authorize the procedure. However, conflicts around this concept arise as paternalism exists as a tradition and is rooted in our milieu as a salient cultural characteristic (18,19). In line with this paradigm, the principle of autonomy is still unknown and considered as foreign among many practitioners and they continue to embrace an unwarranted authoritative and sometimes dismissive attitude towards patients. This way of thinking on grounds of assumptions or ideas like as specialist we are in a superior position with the power to override patients' values and wishes or that patients do not have the knowledge to understand or the sufficient capacity to decide what is best for them undermines the value of informed consent and fails to implement and to fulfil a respect for autonomy-based model in clinical practice.

Over the last two decades, the way we interact with patients has become more symmetrical. It has incrementally shifted from a dominant paternalism-based model to one that advocates for respect for patient autonomy. This transition has occurred because of technological, social, cultural, legal, and ethical developments (18,20-22). The evolving nature of this new clinician-patient relationship challenges oral and maxillofacial surgeons' commitment to beneficently guide patients to the best decision, namely to a more participatory model of autonomous choice.

To do good

As evolving moral actors, oral and maxillofacial surgeons need not only to respect and to treat patients autonomously but also to strive for and contribute to their well-being. This action falls under the principle of beneficence, which refers to the basic duty to promote and to do good while preventing and removing conditions that will cause harm (10). This endeavour indicates we shall be dedicated above all else to providing the best possible care for our patients in accordance with their values, needs, feelings and agreed-

upon treatment, namely, to act in their best interest. Beneficence entails the virtue of benevolence and of reverent consideration (21,23). Our Code of Ethics emphasizes beneficence as one of the principles governing our duties and notes as overarching goal to provide high quality health care services to those in need and in a timely manner[1]. All our efforts should be directed to accomplishing this objective in any clinical setting. In providing high quality care to patients –defined as the degree to which the treatment provided increases the likelihood of a desired health care outcome and is consistent with current professional knowledge (24) –the challenge to beneficence starts when clinicians delegate or transfer complete authority to a trainee –with or without supervision– or to an auxiliary staff member to perform a specific task or procedure that should be performed by themselves. Entrusting an inappropriate person with a complex clinical task places the patient at an unacceptable level of risk of harm. Certainly, high quality care is only achieved when a responsible clinician personally dictates care and performs the procedure.

The standard of care

In contrast to the principle of beneficence, whose language is one of positive requirements of action, we also are morally obligated not to inflict or to impose risk of harm to patients (9). This moral imperative is created by the principle of nonmaleficence, which is closely related to and should always be considered together with the principle of beneficence (25,26). Our code of ethics indicates the importance of not carrying out contraindicated surgical procedures or those that undermine patient's well-being, as well as of our responsibility related to the imposition of foreseeable risks of harms (4). In clinical practice, this statement leads to the question on the extent to which we must act to prevent harms or reduce risks that may be likely to occur. The practice of oral and maxillofacial surgery implies per se the imposition of risk –a surgical complication that cannot be reduced or eliminated by skill, care, or technology (27); thus, it defies the principle of nonmaleficence daily. However, law and morality recognize a standard of due care that determines whether the clinician causally responsible for the risk is legally or ethically responsible as well. Accordingly, the standard of care is a specification of the principle of nonmaleficence (7,25). Legally, the term is defined as that degree and type of care that a reasonable competent, skilled, and prudent clinician would do in the same or similar circumstances (28,29). Over the years, the standard of care to what oral and maxillofacial surgeons are held has been guided and set by members of the specialty community by simply adopting certain conducts that have become widespread or via universal norms, clinical practice guidelines or protocols developed and issued by institutional and academic committees. The standard of care is determined on a case-by-case basis, after the fact, by expert testimony and with legislated judicial guidelines. Failure to meet the standard of care is called professional negligence and is one of the elements that needs to be proven in a malpractice lawsuit (30-32). On the other hand, ethically, standard of care is defined as the conscientious application of up-to-date knowledge, competent skill, and reasoned judgement in the best interest of the patient, honoring the autonomy of the patient (30). Challenges concerning the principle of nonmaleficence and hence both dimensions of the professional standard of care arise when clinicians lose the ability to exercise good clinical judgment, viz. prudence, the capacity of practical wisdom (*phronesis)* (11,33). Good clinical judgment is necessary to determine the appropriateness of care or of a surgical procedure based on an analysis of the benefits, risks, and potential harm and on individual patient's needs, priorities, and values. Namely, to provide care that is in the patient's best interest. In practice, potential influences on practical wisdom are demonstrated in different ways: when a clinician's personal secondary interest, usually an economic one overrides the primary duty to patient well-being. When money becomes a driving force the surgical decision-making process is fictitious; it is biased, eroded, and deviated from the expected professional standards. Likewise, the clinician who is not able to recognize the limits of his or her own

professional competence and decide to proceed with cases beyond his or her knowledge or area of expertise may lead to an incident that results in great harm to a patient. Oral and maxillofacial surgeons should know a diploma does not guarantee competence and they are expected to undertake only cases and operations for which they have the appropriate knowledge or sufficient dexterity of the required technique. Whenever a clinician performs a surgical procedure that can be performed better by a more experienced surgeon the principle of "do no harm" is being compromised.

Fairness and equality

The nature of our moral agency compels oral and maxillofacial surgeons to act in line with what is due not only to our patients but to people. Based on an Aristotelian standpoint, the formal principle of justice imposes on us the obligation to render fair, equitable and good treatment to everyone (11,34). In our dealing with patients, staff, trainees, colleagues, and society fairness implies to have an unbiased disposition to treat every individual in a similar way, where they have the option to fulfill their desires or primary needs in the way they wish (35). Likewise, equality refers to providing every patient the same level and quality of care regardless of non-medical or morally irrelevant aspects such as age, race, gender, educational level, and socio-economic status. A serious instance that challenges the essence of the principle of justice in clinical practice is the issue of prejudice, an attitude whose final measurable outcome is the practice of discrimination (36). The clinician who displays an unpleasant and uncaring attitude towards a poor or less educated patient, who does not take the time to examine, explain a condition or therapy and to answer the questions; who avoids provision of treatment or follow-up, who denies remedy in the event of an adverse outcome, who assigns care to trainees not yet prepared for unsupervised responsibility; who chronically offends his or her staff, who takes advantage of his or her fellows associates, who is always late or never attends rounds or meetings with students or trainees or who mistreats, humiliate and abuses them exemplifies common unfair and unjust actions that show disrespect for the dignity of persons and that unreasonably lead to the provision of a lower quality of health care service and the undermining of interpersonal and professional relationships.

Closing reflection

The essential ethical ideals of oral and maxillofacial surgery involve recognizing and honoring patients' autonomy in informed treatment decisions, furthering patients' own legitimate values, acting in patients' best interests and treating people fairly. As obligatory standards they underpin the humanitarian nature of our specialty and forge the moral environment in which optimum care is provided and interpersonal relationships between clinicians, patients and colleagues are fostered. However, it is very unfortunate that some of these standards have undergone a steady decline at one time. Changes in socio-economic factors have cultivated and elicited the emergence and flourishing of a new set of academic, institutional, and self-centered values and goals focused on business, profit, wealth, image, fame, and status that have affected former social practices and epistemic conditions of moral agency. This form of moral regress has altered the way oral and maxillofacial surgery is being practiced in our milieu, resulting in instances of socially insensitive and ethically unprofessional behaviours. In the context of this new moral order there are reasons to fear that the essence of ethics and professionalism will be extinguished forever if as individuals, academics and community do not stand firm and put aside our affective ignorance (37) –i.e. choosing not to know what we can and should know; something that is morally important– and regain the acknowledgment and understanding of already existing moral concepts and ethical rules (38).

References

1. Chirivi JM. Historia de una ilusión. Rev Odontol Maxilo. 2006; 1(4): 201-202.
2. Castro-Núñez J. Waldemar Wilhelm: father of oral and maxillofacial surgery in Colombia. J Hist Dent. 2011 Winter; 59(3): 153-158.
3. Relman AS. Medical professionalism in a commercialized health care market. J Am Med Assoc. 2007; 298(22): 2668-2670. https://dx.doi.org/10.1001/jama.298.22.2668
4. República de Colombia. Ley estatutaria 35 de 1989, Sobre ética del odontólogo colombiano. Diario Oficial No. 38.733. Bogotá, Colombia: Congreso de la República; 1989.
5. Jaramillo JA, Pulido JH, Castro Núñez JA, Bird WF, Komabayashi T. Dental education in Colombia. J Oral Sci. 2010 Mar;52(1):137-43. https://dx.doi.org/10.2334/josnusd.52.137
6. Yavari N. Does medical education erode medical trainees' ethical attitude and behavior? J Med Ethics Hist Med. 2016 Nov 23; 9: 16.
7. Nash DA. On ethics in the profession of dentistry and dental education. Eur J Dent Educ. 2007 May;11(2):64-74. https://dx.doi.org/10.1111/j.1600-0579.2007.00448.x
8. Torres-Quintana MA, Romo OF. Bioética y ejercicio profesional de la odontología. Acta Bioeth. 2006 Ene; 12(1): 65-74.
9. Beauchamp TL, Childress JF. Moral norms. In: Principles of biomedical ethics. 5th ed. Oxford (UK): Oxford University Press; 2009: 1-29.
10. Ferro M, Molina Rodríguez L, Rodríguez GWA. La bioética y sus principios. Acta Odontol Venez. 2009 Jun; 47(2): 481-487.
11. Garcés Giraldo LF, Giraldo Zuluaga C. Virtudes éticas en Aristóteles: razón de los deseos y sus acciones para lograrlas. Rev Virt Univ Catól del Norte. 2014; 41: 70-78.
12. Beauchamp TL, Childress JF. Moral Character. In: Principles of biomedical ethics. 5th ed. Oxford (UK): Oxford University Press; 2009: 30-63.
13. Churchill LR. The American Association for Thoracic Surgery 2016 ethics forum: Working virtues in surgical practice. J Thorac Cardiovasc Surg. 2017 May; 153(5): 1214-1217. https://dx.doi.org/10.1016/j.jtcvs.2016.09.015
14. Beauchamp TL, Childress JF. Respect for Autonomy. In: Principles of biomedical ethics. 5th ed. Oxford (UK): Oxford University Press; 2009: 99-148.
15. Varkey B. Principles of Clinical Ethics and Their Application to Practice. Med Princ Pract. 2021; 30(1): 17-28. https://dx.doi.org/10.1159/000509119
16. Booth S. A philosophical analysis of informed consent. Nurs Stand. 2002 Jun 12-18; 16(39): 43-46. https://dx.doi.org/10.7748/ns2002.06.16.39.43.c3211
17. Wisk TM. Informed consent. Plast Surg Nurs. 2007 Oct-Dec; 27(4): 206-209. https://dx.doi.org/10.1097/01.PSN.0000306187.80565.0e
18. Cañete Villafranca R, Guilhem D, Brito Pérez K. Paternalismo médico. Rev Med Electrón. 2013 Abr; 35(2): 144-152.
19. Drane JF, Fuenzalida HL. Medical ethics in Latin America: a new interest and commitment. Kennedy Inst Ethics J. 1991 Dec; 1(4): 325-338. https://dx.doi.org/10.1353/ken.0.0179
20. Weiss GB. Paternalism modernised. J Med Ethics. 1985 Dec; 11(4): 184-187. https://dx.doi.org/10.1136/jme.11.4.184
21. Beauchamp TL, Childress JF. Beneficence. In: Principles of biomedical ethics. 5th ed. Oxford (UK): Oxford University Press; 2009: 197-239.
22. Rodriguez-Osorio CA, Dominguez-Cherit G. Medical decision making: paternalism versus patient-centered (autonomous) care. Curr Opin Crit Care. 2008 Dec; 14(6): 708-713. https://dx.doi.org/10.1097/MCC.0b013e328315a611
23. Kinsinger FS. Beneficence and the professional's moral imperative. J Chiropr Humanit. 2009 Dec; 16(1): 44-46. https://dx.doi.org/10.1016/j.echu.2010.02.006
24. IOM. Medicare: A Strategy for Quality Assurance: Volume 1. Washington (DC), US: National Academies Press; 1990.
25. Beauchamp TL, Childress JF. Nonmaleficence. In: Principles of biomedical ethics. 5th ed. Oxford (UK): Oxford University Press; 2009: 149-196.
26. Gillon R. "Primum non nocere" and the principle of non-maleficence. Br Med J (Clin Res Ed). 1985 Jul 13; 291(6488): 130-131. https://dx.doi.org/10.1136/bmj.291.6488.130
27. Curley AW. The law and dentoalveolar complications: trends and controversies. Oral Maxillofac Surg Clin North Am. 2011 Aug; 23(3): 475-484. https://dx.doi.org/10.1016/j.coms.2011.04.003
28. Curley AW, Peltier B. Standard of care: the legal view. J Am Coll Dent. 2014 Spring; 81(1): 53-58.
29. Selbst AG. Standard of care: so who decides? Oral Surg Oral Med Oral Pathol Oral Radiol Endod. 1997 Jun; 83(6): 637. https://dx.doi.org/10.1016/s1079-2104(97)90306-1

30. Jenson LE. Six common misconceptions about the standard of care in dentistry. J Am Coll Dent. 2014 Spring; 81(1): 59-63
31. Bhadauria US, Dasar PL, Sandesh N, Mishra P, Godha S. Medico-legal aspect of dental practice. Clujul Med. 2018 Jul; 91(3): 255-258. https://dx.doi.org/10.15386/cjmed-764
32. Morris C, Chawla G, Francis T. Clinical negligence: duty and breach. Br Dent J. 2019 May; 226(9): 647-648. https://dx.doi.org/10.1038/s41415-019-0312-9
33. Elledge R, Brennan PA, Mohamud A, Jones J. Phronesis and virtue ethics: the future of surgical training? Br J Oral Maxillofac Surg. 2020 Feb; 58(2): 125-128. https://dx.doi.org/10.1016/j.bjoms.2019.12.002
34. Beauchamp TL, Childress JF. Justice. In: Principles of biomedical ethics. 5th ed. Oxford (UK): Oxford University Press; 2009: 240-242
35. Dator J, Pratt D, Seo Y. What Is fairness? In: fairness, Globalization, and Public Institutions: East Asia and Beyond. Honolulu: University of Hawai'i Press; 2006: 19-34. https://dx.doi.org/10.2307/j.ctv3zp081.6
36. Guilfoyle J, Kelly L, St Pierre-Hansen N. Prejudice in medicine: Our role in creating health care disparities. Can Fam Physician. 2008 Nov; 54(11): 1511-1520
37. Hermann J. The dynamics of moral progress. Ratio. 2019 Dec; 32(4): 300-311. https://dx.doi.org/10.1111/rati.12232
38. Guerrero Berrocal JS. Ética y responsabilidad clínica en cirugía oral y maxilofacial en Colombia. CES Odontol. 2021 Ene; 34(1): 145-152.

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